

STATE OF CALIFORNIA
DEPARTMENT OF PERSONNEL ADMINISTRATION

Dental Benefits

For Active and Retired Employees



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A. Introduction and General Information

This Dental Benefits Handbook was prepared by the Department of Personnel Administration to provide general information regarding State-sponsored dental coverage for State of California employees, retirees, and their eligible dependents.

Information in this handbook is supplied solely to provide general information regarding eligibility and enrollment and to assist you in comparing dental plan options. This handbook has no legal force or effect. While it is our intention to be as accurate as possible, any discrepancy between the information contained herein and actual dental plan benefits is controlled by the contracts between the State and the dental plan carriers.

For active employees, questions regarding eligibility for enrollment in the State's Dental Program should be directed to the appropriate personnel office. For retirees, eligibility questions should be directed to the California Public Employees' Retirement System (CalPERS) at 916-326-3970 or 800-237-3345.

Department of Personnel Administration

The Department of Personnel Administration (DPA) Benefits Division administers the State's Dental Program. DPA secures and administers contracts with dental companies to provide benefits to active State employees, retirees, and their dependents. Additionally, DPA is responsible for communicating policies and procedures regarding dental eligibility and enrollment, coordinating dental open enrollment periods, and providing information, guidance, and training to personnel office staff on issues relating to the State's Dental Program.

State-Sponsored Dental Plans

DPA currently contracts with Delta Dental (Delta) for an indemnity plan and a preferred provider option plan. DPA also contracts with four prepaid dental plans. These prepaid plans are: Health Net Dental; Private Medical Care, Inc. (PMI); SafeGuard Health Plan (SafeGuard); and GE Wellness Plan Dental.

Here are brief descriptions of the three kinds of dental plans: **prepaid**, **indemnity**, and **preferred provider option** plans.

A **prepaid** plan requires you and your eligible dependents to select a dental provider when you enroll, choosing from a list of dentists who contract with the plan. These dentists, located only in California, are paid a monthly contracted fee by the dental plan for every State employee, retiree, and dependent who chooses to receive services from their office. No monthly premium is deducted from your paycheck or

retirement check; the premium is paid in full by the State. (See page 11 for more details about the prepaid plans.)

An **indemnity** plan allows you to receive services from any licensed dentist worldwide. However, benefits are maximized when you receive services from a contracting Delta dentist. The plan pays a percentage of the costs for each specific type of dental treatment. You are responsible for paying any remaining balance based on the type of dental treatment you receive. A monthly premium co-payment will be deducted from your paycheck or retirement check. (See page 15 for more information about the State-sponsored indemnity plan.)

A **preferred provider option** plan allows you to select any licensed dentist you wish. However, you receive the maximum benefits available under the program when you choose one of the dentists in the plan's network, similar to the indemnity plan. Individuals who enroll in the plan are required to pay a monthly premium co-payment. Currently, employees and retirees enrolled at the one-party code (i.e., self only) do not pay a monthly premium co-payment. (See page 18 for more information about the State-sponsored preferred provider option plan.)

California Association of Highway Patrolmen (CAHP) Dental Plan

The California Association of Highway Patrolmen (CAHP) administers the indemnity dental plan (Blue Cross) for Bargaining Unit 5 employees. The exclusive representative of Bargaining Unit 5 contracts directly with Blue Cross to provide dental insurance to the unit's members and has administrative responsibility for such coverage. All newly hired represented employees in Unit 5 must elect their dental coverage from one of the State-sponsored prepaid dental plans. After completing the 24-month restriction period, Unit 5 employees who are CAHP members may enroll or change to Blue Cross.

For more information on the 24-month restriction period, employees should contact their personnel office. For information regarding the CAHP dental plan, Unit 5 employees should contact the CAHP Benefits Trust at 916-452-6751 or 800-734-2247.

California Correctional Peace Officers Association (CCPOA) Dental Plans

The California Correctional Peace Officers Association (CCPOA) administers the Primary Plan (indemnity) and Western Dental Plan (prepaid) for Bargaining Unit 6 employees. The exclusive representative of Unit 6 contracts directly with its dental carriers for dental benefits for its members and has administrative responsibility for such coverage. Unit 6 employees have 60 days from the date of hire, or when they become eligible, to enroll in the union-sponsored dental plan. All newly hired or newly eligible Unit 6 employees are required to enroll in Western Dental for 12 consecutive months from the effective date of their enrollment before they can change to the Primary Dental Plan.

Unit 6 employees should contact Western Dental at 800-992-3366 or contact CCPOA directly at 916-373-6676 or 800-468-6486 if they have questions or issues concerning their dental coverage.

Dental Benefits Assistance – Who To Call

If you need assistance with your dental coverage, the lists below show you who you need to call for assistance – your personnel office, CalPERS, or DPA.

Personnel Office (if you are an active employee)

CalPERS (if you are retired): (800) 237-3345

- To find out who is your current dental carrier
(**Note:** This information also appears on your pay stub or retirement check/statement.)
- To determine whether a particular enrollment change is permitted outside the dental open enrollment period
- For questions regarding the dental open enrollment process
- To verify dental enrollment effective dates
- For information regarding adding/dropping dependents from your dental coverage
- To report the death of a spouse or dependent
- To continue dental coverage of enrolled dependents following the death of an active or retired State employee
- To report an incorrect premium deduction or dental plan coverage on your pay stub or retirement check/statement

Department of Personnel Administration (DPA)

- For assistance resolving problems with your dental plan or dentist that you are unable to resolve through your dental plan's customer service department or through the complaint procedure outlined in your dental plan's Evidence of Coverage Booklet
- For questions or concerns regarding your monthly dental plan co-payment premium
- For questions about your dental coverage

Mailing addresses and telephone numbers for DPA and the individual dental plans are listed on page 23.

Frequently Asked Questions Regarding Dental Coverage In General

(Questions regarding eligibility, open enrollment, and the plans themselves are covered in separate sections of this handbook)

1. When will my dental enrollment/plan change become effective?

Any allowable changes made during the year become effective the first day of the month following the date your personnel office receives your completed Dental Plan Enrollment Authorization Form (STD. 692), if you are an active employee, or the first day of the month following the date CalPERS receives your written request, if you are retired. Enrollment changes made during the annual open enrollment period become effective January 1 of the following year.

2. Once I've selected a dental plan, may I change dental plans if my dentist cancels his/her contract with the dental carrier?

No. You may change dental plans outside the annual open enrollment period **only** if your dental plan is no longer available to you. For example, if you move to an area where your dental plan is more than 50 miles from your residence, you may enroll in another plan. If you have any questions, contact your personnel office (if you are an active employee), or call CalPERS at 916-326-3970 or 800-237-3345 (if you are retired).

3. What should I do if I have a problem or complaint regarding my dental plan or dentist?

Many problems can be resolved by contacting your dental plan's customer service department. You also should refer to the complaint procedure outlined in your dental plan Evidence of Coverage Booklet, available from your personnel office, CalPERS, or your dental carrier. If you are unable to resolve your complaint through your carrier, you may contact DPA for assistance (see page 23 for contact information).

4. What should I do if the payroll deduction for my dental plan is incorrect, or is not shown on my pay stub or retirement check?

When you enroll in a State-sponsored dental plan or change the coverage, it is important to carefully check your pay stub or retirement check/statement to verify that the premium is being paid to the correct dental plan. For prepaid plans, the State pays 100 percent of the cost of the premium, which should be reflected on your pay stub or retirement check/statement.

If the deduction is incorrect, or has not started by the effective date, report the discrepancy to your personnel office (if you are an active employee) or CalPERS Health Benefit Services Division (if you are retired).

5. As a retiree, what happens if I have insufficient funds in my retirement allowance to pay my share of the premium?

You may request, in writing, to pay the balance directly to CalPERS. For more information, contact CalPERS at (800) 237-3345.

B. Eligibility Information

Active State Employees

Who is eligible to enroll or continue enrollment in the State's Dental Program?

- All permanent State employees who are appointed half time or more, and limited term or TAU employees whose time base is half-time or more and who have been appointed six months or more.
- Permanent Intermittent (PI) employees who have been credited with a minimum of 480 hours during a six-month qualifying period starting January 1 and ending June 30, or starting July 1 and ending December 31.

Eligible new employees have **60 days** from the date of hire or the date they become eligible to enroll in a dental plan. Employees may enroll in a State/Union-sponsored dental plan through their personnel office using the standard Dental Plan Enrollment Authorization Form (STD. 692). Eligible employees who do not enroll at the time of hire or eligibility may enroll during the annual dental open enrollment period.

Contact your Personnel Office if you have enrollment or eligibility questions.

State Dental Plan Restrictions For Newly Hired State Employees

All eligible newly hired represented employees in Bargaining Units (BU) 1 through 21 (with the exception of BU 2*, BU 7, BU 8, BU 16, BU 17*, BU 18, and BU 19) are required to enroll in a prepaid plan until they have completed 24 consecutive months of State service. At the end of the 24-month period, those employees who elected a prepaid dental plan will have **60 days** to change their enrollment to an indemnity or preferred provider option plan. See page 2 for information on the 24-month restriction for Unit 5. See page 2 for information on the 12-month restriction for Unit 6.

All eligible represented employees who reinstate after a permanent separation and who previously had 24 consecutive months of State service may enroll in either an indemnity, preferred provider option plan, or prepaid plan at the time of hire.

*Effective July 1, 2002

All eligible newly hired excluded employees may select the indemnity, preferred provider option plan, or prepaid plan at the time of hire.

Retired State Employees

If you are a retired State employee, you are eligible to continue enrollment in the State's Dental Program if you retired within 120 days after your date of separation **and** you receive a retirement allowance from CalPERS. If you are enrolled in a State-sponsored dental plan, your personnel office will automatically submit the STD. 692 to CalPERS to continue your dental enrollment into retirement. Retired employees who did not continue dental coverage into retirement may enroll during the annual dental open enrollment period.

Bargaining Unit 5 employees (CAHP) who retired on or after September 30, 1992, may elect to continue enrollment in their Union-sponsored indemnity plan or change to a State-sponsored dental plan. Under the terms of the Memorandum of Understanding (MOU) between the CAHP and DPA, this is an irrevocable one-time election.

Bargaining Unit 6 employees (CCPOA) who are enrolled in a Union-sponsored dental plan must change to a State-sponsored dental plan and retire within 120 days after their date of separation to continue their dental coverage.

California Public Employees' Retirement System (CalPERS)

CalPERS maintains the dental benefit enrollment records for all State retirees, processes retirees' dental enrollments, and submits eligibility information to the appropriate dental plan. It is important that you keep your home address current at all times, even if your retirement check is deposited directly into your bank account. This helps ensure you receive timely information about your State-sponsored dental benefits that may be mailed to your home address by DPA or CalPERS. Report address changes to CalPERS at the address below (be sure to include your Social Security number and telephone number):

California Public Employees' Retirement System
Health Benefit Services Division
P. O. Box 942716
Sacramento, CA 94229-2716

If you are a retired State employee and have any questions regarding your eligibility, contact CalPERS, Health Benefits Services Division at:

TOLL FREE 1-800-237-3345

Dependent Eligibility

Employees and retirees eligible for benefits may also enroll eligible family members.

1. Family Member

Eligible family members include an employee's or retiree's spouse or domestic partner (as recognized by the State of California) and eligible children (see sections 2 and 3 below for discussion of eligible children).

The following documents must be provided at the time of initial enrollment of a spouse or domestic partner: A copy of the marriage certificate or the Declaration of Domestic Partnership and signed Statement of Financial Liability, as filed with the Secretary of State's Office. (Statement of Financial Liability forms are available from CalPERS.) For audit purposes, these documents are maintained along with the dental enrollment materials in active employees' confidential personnel files.

2. Eligible Children

Children under the age of 23 are eligible for enrollment if they:

- 1) reside in the household, and
- 2) have never been married.

Such children may include the eligible employee's or retiree's birth children, adopted children or those children placed for adoption, stepchildren, children of a domestic partner, and children living in the household in a parent-child relationship who are **economically dependent** on the employee or retiree. However, if the economically dependent child is not a birth child of the eligible employee or retiree, the birth parents of that child may **not** also reside in the eligible employee's or retiree's home unless there has been a court-ordered custody change to the employee or retiree.

To enroll an economically dependent child, an eligible employee or retiree needs to complete a State Dental Program Affidavit of Eligibility (DPA 25).

3. Medically Disabled Children

A child may continue to be enrolled after age 23 if he or she was enrolled at the time of the employee's or retiree's initial enrollment and is:

- incapable of self support because of physical disability or mental incapacity, and
- dependent on the eligible employee or retiree for support and care.

For more details regarding the enrollment criteria for disabled children, contact your personnel office or CalPERS.

Frequently Asked Questions Regarding Eligibility

1. What would cause a family member to lose eligibility for coverage?

Any of the following events would cause a family member or dependent to lose eligibility; his or her coverage would end on the last day of the month in which this event occurred:

- The family member becomes eligible to enroll as a State employee in a State-sponsored dental plan under his or her own name (dual coverage is not allowed)
- The child turns 23 or marries
- The child moves out of the household and the dental plan subscriber is no longer financially responsible for that child
- A final divorce decree is granted or a domestic partnership is terminated
- Coverage of the dependent is voluntarily dropped

When a family member or other dependent ceases to be eligible, he or she must be dropped from your coverage. Notify your personnel office (if you are an active employee) or CalPERS (if you are retired) as soon as possible, as you do not need to wait until open enrollment. You will be liable for any expenses incurred after this person loses eligibility. Refer to page 20 for information about continuation coverage under COBRA.

You also may voluntarily drop dependents from coverage by submitting a request to your personnel office (if you are an active employee) or CalPERS (if you are retired). Such requests may be submitted at any time.

2. Can a person be covered under more than one State-sponsored dental plan?

No. This would be considered dual coverage, which is not allowed. If a situation involving dual coverage is discovered, it must be corrected retroactively to the date dual coverage began. In addition, a dental plan may request reimbursement for any claims paid.

NOTE: Married employees, domestic partners, and retirees may not split coverage for their dependent children. In other words, all eligible children in a household enrolled in a State-sponsored dental plan must be covered through the same subscriber.

3. In the event of my death, what happens to dental coverage for my family members?

Departments are required to continue paying the employer contributions for a covered employee's spouse, domestic partner, and other eligible family members for up to 120 days following an employee's death. During this time, CalPERS will determine if the spouse or other family members are eligible for continuation coverage. (The law creating this grace period -- AB 1639, Chapter 926, Statutes of 1999 -- is based on collective bargaining agreements with all 21 bargaining units.)

After 120 days, your surviving family member(s) will be eligible to continue your current coverage if they meet all the following criteria:

- they were enrolled as your dependents at the time of your death;
- they qualify for a monthly survivor allowance from CalPERS; and
- they continue to qualify as family members.

Questions regarding continuation of dental plan coverage should be directed to your personnel office (if you are an active employee) or CalPERS (if you are retired) at 916-326-3970 or 800-237-3345.

To report the death of a dental plan enrollee, contact CalPERS at (916) 326-3848, or write to CalPERS at P.O. Box 942714, Sacramento, CA 94229-2714.

NOTE: Surviving enrolled family members who do not qualify to continue their current coverage are eligible for continuation coverage under COBRA (refer to page 20 for details).

C. Open Enrollment Information

Each year, a dental open enrollment period is held to allow eligible active and retired State employees to enroll in a dental plan, change plans, and add or drop eligible family members. Open enrollment typically is held from September through mid-October. It is coordinated by DPA in cooperation with the State Controller's Office (SCO) and CalPERS.

Changes made during the Annual Dental Plan Open Enrollment Period are effective January 1 of the following year.

State employees may obtain enrollment information from their personnel office. Retired employees should contact CalPERS for this information.

Frequently Asked Questions Regarding Open Enrollment

1. May I change dental plans and add/delete family members during the open enrollment period?

Yes. The open enrollment period is the time when you may change your dental plan coverage. However, if during the year you experience a change in family status (e.g., marriage, domestic partner relationship, newborn child), you may add these family members to your coverage if you make the request within **60 days** of the date the change in family status occurs. You will be required to provide the date of the family status change to your personnel office (if you are an active employee) or CalPERS (if you are retired).

If you need to drop a family member from coverage because he or she becomes ineligible, you should take this action as soon as possible; do not wait for open

enrollment, as you will be liable for any costs incurred by this person after he or she ceases to be eligible.

2. How do I enroll or make allowable changes to my dental coverage during the open enrollment period?

If you are an active employee, contact your personnel office to enroll or make changes to your dental coverage. If you wish to make any changes, complete a STD. 692 form.

If you are a retired employee, check with CalPERS regarding your enrollment information. If you wish to make any allowable changes, send a letter to CalPERS requesting the change. (Refer to page 7 for CalPERS' address.) When adding dependents, be sure to include the allowable event (e.g., marriage, new domestic partnership, divorce, childbirth, etc.) and full name, Social Security number, and date of birth of the eligible dependent, and sign and submit any required affidavits.

3. Can a surviving spouse add new family members during open enrollment?

Yes, but only if the new family member had a family relationship to the deceased employee or retiree prior to the employee's or retiree's death (e.g., the active employee's or retiree's unborn child).

D. Prepaid Dental Plans

Health Net Dental, PMI, Safeguard, and GE Wellness Plan Dental

Health Net Dental, PMI, SafeGuard, and GE Wellness Plan Dental are the four State-sponsored **prepaid** dental plan providers. Health Net Dental offers two plans: a Standard Plan for represented employees, and an Enhanced Plan for excluded employees and retirees.

The State pays 100% of the monthly premium for the prepaid plans, so there is no monthly premium co-payment deducted from your paycheck or retirement check. There are no claim forms, deductibles, or maximum allowable benefits.

Prepaid plans provide dental services through pre-selected participating dentists throughout California. When you enroll in one of these plans, you select a dentist from the list of dentists who participate in the plan you have chosen. (You and eligible family members/dependents covered under your enrollment must use the same dentist.) You may change dentists, either upon your request or if your dentist leaves the plan, to another dentist who participates in your plan. You may change dental plans if you move and your plan has no participating dentists within 50 miles of your new residence.

A prepaid dental plan pays its participating dentists a contracted monthly fee for each person enrolled in the plan served by that dentist. In return, the dentist provides all basic, preventive, and diagnostic services (e.g., cleanings, checkups, x-rays, fillings, oral surgery, and treatment of tooth pulp and gums). The level of coverage for the enrollee and dependents is the same.

While most dental services are performed at little or no charge to the enrollee, there may be a specific fixed charge for certain types of complex procedures such as root canals. There is a limit on the amount a prepaid provider can charge you for orthodontic services.

To obtain brochures describing each **prepaid** plan and a list of the dentists participating in those plans, contact the dental carriers directly. Their toll-free numbers are:

Health Net Dental	1-800-926-7828
PMI	1-800-422-4234
SafeGuard	1-800-880-1800
GE Wellness Plan Dental	1-800-333-9561

Frequently Asked Questions Regarding Prepaid Dental Plans

Note: The information provided below offers only brief descriptions of the currently available prepaid dental plans. Please consult each plan's Evidence of Coverage booklet or call the plan directly for more detailed explanations.

1. If I enroll in a prepaid dental plan, will I receive an identification card?

Yes. Shortly after your eligibility is established by your dental plan and you have selected a dentist, you will receive an identification card. The card is a reminder of which dental office you selected. Please confirm the address and telephone number of your selected dental provider with your dental plan carrier.

2. What if there are no participating dentists in my service area for any of the prepaid plans?

If you are unable to locate a participating provider within 50 miles of your residence, contact the customer service departments of the prepaid plans for assistance. If it is determined that there are no prepaid providers in your service area, contact your personnel office (if you are an active employee) or CalPERS (if you are retired) for further assistance. (**Note:** The State-sponsored prepaid plans are only available in California.)

3. May I choose any dentist I want if I enroll in a prepaid plan?

No. The dentists available through each prepaid plan have contracted with that plan to provide services to its enrollees. Your choice is restricted to dentists who have contracted with your plan (called “participating dentists”). Contact the dental plan directly to obtain a list of its participating dentists or to verify whether a particular dental provider is on the plan’s list.

4. Once I have selected a prepaid dentist and/or dental office, do I have to remain there?

No. If for any reason you feel you need to change dental providers, simply contact your dental plan; the customer service representative will assist you in locating another dentist from the plan’s list of participating dental providers.

5. What happens if my dentist decides to no longer participate in my prepaid plan?

Your dental plan will notify you if your dentist stops participating in the plan. You will be provided with the name of a new dentist or given the opportunity to select another participating dentist within 50 miles of your residence. If you are unable to locate another participating dentist in your service area, contact your personnel office (if you are an active employee) or CalPERS (if you are retired).

6. What happens if I am enrolled in a prepaid plan and move out of California?

The State-sponsored prepaid plans are only offered in California. **Before** you move out of the state, contact your personnel office (if you are an active employee) or CalPERS (if you are retired) to change your dental plan; be sure to inform them of your moving date.

7. Do I have to pay monthly premiums for my dependents or myself if I enroll in a prepaid plan?

No. The State of California pays 100% of the monthly premium for you and your dependents enrolled in a prepaid plan.

8. Do I have to pay an annual deductible if I am enrolled in a prepaid plan?

No. There are no annual deductibles under a prepaid plan.

9. What co-payment can I expect to pay if I enroll in a prepaid plan?

While there is no monthly premium co-payment deducted from your paycheck or retirement check, depending on the type of dental service performed, you could be charged a co-payment. This co-payment is payable at the time the service is rendered. For a listing of covered dental services and applicable co-payments, you may contact the dental plans using the contact information on page 23.

10. What actions should I take in an emergency if I am enrolled in a prepaid plan?

First, you should contact your dentist or dental office. If the emergency occurs after normal business hours, or you are advised that there is no plan provider available, or you are more than 50 miles from your selected plan provider, you may receive treatment for the **relief of pain** from any non-plan provider. You **must** telephone your dental plan before obtaining out-of-area emergency care. Your plan will reimburse up to \$400 per enrolled member per calendar year for emergency services.

11. How do I access specialist services?

The prepaid plans offer services in most dental specialties, including periodontics (treatment of diseased gums and bones), endodontics (root canal-therapy), and oral surgery procedures. If your dental provider refers you to a specialist, the referral must be approved by the prepaid dental plan.

12. Do my dependents have the same level of benefits that I do in my prepaid plan?

Yes. The benefits for employees, retirees, and their dependents are identical under a prepaid dental plan.

13. If I am not currently enrolled in a prepaid plan, what things should I consider before I decide to change dental plans?

- **Is it important to you to maintain your current dentist?**

If your answer is NO, enrolling in a prepaid plan and selecting one of its participating dental providers may be a good choice for you.

- **Is the location of your dentist an issue for transportation purposes?**

If your answer is NO, you may want to review the list of participating dental providers for each prepaid plan. You may find a provider within easy access by car or public transportation.

- **Are your out-of-pocket dental costs a significant financial consideration?**

If your answer is YES, you should be aware that the prepaid plans have **no** monthly premium co-payment or annual deductibles, and most services are provided at little or no cost to you.

- **Do you live outside of California?**

If your answer is YES, you need to be aware that the prepaid plans are only available in California.

14. How can I find out more about the State-sponsored prepaid dental plans?

Refer to the Directory on page 23. It contains the addresses and toll-free telephone numbers of all four State-sponsored prepaid dental plans. Before changing plans, it is recommended that you request a copy of the plan brochure and list of participating dental providers for any plans you are considering. Review this information and select a dentist from the provider list **prior** to changing plans.

If you decide to change dental plans, be aware that the prepaid plans provide less flexibility in that you are required to choose your dentist from a list of dental providers. However, the prepaid plans provide benefits at less cost to you. (There is a comparison of dental plans beginning on page 24.)

E. Indemnity and Preferred Provider Option Dental Plans

Delta Premier Plan

Delta Dental Plan of California (Delta) is the carrier for the State-sponsored indemnity dental plan (DeltaPremier) available to all retirees, excluded employees, and represented employees in Bargaining Units 1 through 21 with the exception of Bargaining Units 5 and 6, which have their own union indemnity plans (see page 2).

DeltaPremier provides two levels of benefit coverage:

- Basic Plan -- for rank-and-file employees, retirees, and their dependents, and
- Enhanced Plan -- for excluded employees and their dependents.

DeltaPremier allows you to choose to receive services from any licensed dentist, although you may have higher out-of-pocket costs if you receive services from a “non-Delta” dentist. Through Delta’s participating dentists, you have full access to specialty care and guaranteed benefits through Delta’s large network of dentists throughout the United States and abroad.

When you receive services from a participating Delta dentist, Delta pays the dentist directly, based on the fee agreement between Delta and the dentist. If the dentist's charges exceed the fee paid by Delta, you are responsible for paying the remainder of the bill and any applicable annual deductible.

If you receive treatment from a non-Delta dentist, either in California or out-of-state, you are responsible for paying the dentist's entire bill. To claim reimbursement, you need to submit an itemized receipt with a standard dental claim form to Delta. Your reimbursement will be based on Delta's set fee schedule, called Usual, Customary, and Reasonable (UCR) fees for California.

Frequently Asked Questions Regarding The Indemnity Dental Plan

1. What is my DeltaPremier Group Number?

Your DeltaPremier dental group number is 9949.

2. Will I receive an ID Card?

Delta will send you an identification card indicating your enrollment in the DeltaPremier Plan and your dental group number. When you or a covered dependent/family member goes to the dentist, you will need to provide this group number (9949) and the Social Security number of the primary enrollee (i.e., the State employee or retiree). The dental office will verify your eligibility and covered benefits directly with Delta.

3. Do I have to complete a claim form when I go to a Delta dentist?

Although claim forms are required, the forms will be completed for you at no charge if you receive services from a participating Delta dentist. If you receive services from a non-Delta dentist, you may be required to complete the forms yourself or pay a fee to have the dentist's office do it for you.

4. How do I obtain an Evidence of Coverage (EOC) booklet for the DeltaPremier Plan?

When you enroll in the DeltaPremier Plan, Delta mails you an EOC booklet with your ID card. Your personnel office also may have a small supply of these booklets. If you do not receive your booklet, contact Delta at **1-800-225-3368** to request an EOC booklet for Group #9949.

5. If I enroll in DeltaPremier, do I have to pay a monthly premium co-payment?

Yes. This premium co-payment is deducted each month from your paycheck or CalPERS retirement check. The current monthly premium co-payments for DeltaPremier Basic and Enhanced plans are listed below.

- | | |
|--|----------------|
| • Party Code 1 (Self only) | \$10.12 |
| • Party Code 2 (Self plus one dependent) | \$16.07 |
| • Party Code 3 (Self plus two or more dependents) | \$22.46 |

NOTE: For active State employees enrolled in the Consolidated Benefits Program (CoBen), the monthly premium co-payment may vary depending on the employee's other CoBen benefit choices.

6. What is the level of benefits under the DeltaPremier Enhanced Plan?

For excluded employees in the DeltaPremier Enhanced Plan, there is an annual maximum benefit of \$2,000 for both the employee and each eligible dependent. The level of benefits for each participating family member is the same as the level of benefits for the employee. There is a \$25 deductible for each family member (maximum of \$100 per family per year). The required \$25 deductible for each participant is waived for preventive and diagnostic care.

The annual deductibles do not apply to Diagnostic and Preventive Benefits such as x-rays, examinations, and cleanings. If the dental costs exceed the annual maximum, the employee or retiree is responsible for paying the difference.

7. What is the level of benefits under the DeltaPremier Basic Plan?

For represented employees and retirees in the DeltaPremier Basic Plan, there is an annual maximum benefit of \$2,000 for employees and retirees and \$1,000 for each dependent. For some services, the level of benefits for the enrolled dependent is less than the level of benefits for the employee or retiree. There is a \$50 deductible for each family member (maximum of \$150 per family per year). The required \$50 deductible for each participant is waived for preventive and diagnostic care.

The annual deductibles do not apply to Diagnostic and Preventive Benefits such as x-rays, examinations, and cleanings. If the dental costs exceed the annual maximum, the employee or retiree is responsible for paying the difference.

The Charts on pages 24 and 25 provide additional coverage information. For a detailed explanation of the limitations and exclusions of the DeltaPremier plans, consult the Evidence of Coverage booklet, available by Delta at 1-800-225-3368.

DeltaPreferred Option Plan

Delta also is the carrier for the State-sponsored “preferred provider option” dental plan, called DeltaPreferred Option (DPO).

The DeltaPreferred Option offers higher benefit levels when its enrollees receive services from a participating DPO dentist. However, enrollees may choose a non-DPO dentist and still be covered. When you receive services from a participating DPO dentist, your costs are based on a discounted fee agreement between Delta and the dentist.

If you receive services from a Delta dentist who is a non-DPO dentist, your benefits will be reduced. You will be responsible for your share of the costs up to Delta’s allowed amounts under the provider’s filed fee agreement with Delta for the service or services you received. Fees are based on the Usual, Customary, and Reasonable (UCR) fee for California.

If you receive services from a non-DPO, non-Delta dentist, you are responsible for paying the full bill directly to the dentist at the time of service and up to the billed amount. Your reimbursement from Delta may be substantially lower. To claim reimbursement, submit your itemized receipt with a standard claim to Delta for review and reimbursement. The reimbursement will be sent directly to you. You may obtain a claim from Delta.

To see if you’re current dentist is a participating DPO dentist, or for more information on the DPO dental plan, contact Delta at 1-800-225-3368.

Frequently Asked Questions Regarding

The DPO Dental Plan

1. What is my DPO Group Number?

Your DPO Group Number is 9946.

2. Will I receive an ID Card?

Delta will send you an identification card indicating your enrollment in the DPO Plan and your dental group number. When you or a covered dependent/family member goes to the dentist, you will need to provide this group number (9946) and the Social Security number of the primary enrollee (i.e., the State employee or retiree). The dental office will verify your eligibility and covered benefits directly with Delta.

3. Do I have to complete a claim form when I go to a DPO dentist?

Although claim forms are required, the forms will be completed for you at no charge if you receive services from a participating DPO dentist.

If you receive services from a non-DPO dentist, you may be required to complete the forms yourself or pay a fee to have the dentist's office do it for you. The dental office should be able to provide you with the claim form, or you may contact Delta to have a claim form sent to you.

4. How do I obtain an Evidence of Coverage (EOC) Booklet for the DPO Plan?

When you enroll in the DPO Plan, Delta will mail you an EOC Booklet with your ID card. Your personnel office also may have a small supply of these booklets. If you do not receive your booklet, contact Delta at 1-800-225-3368 to request an EOC booklet for Group #9946.

5. If I enroll in the DPO Plan, do I have to pay a monthly premium co-payment?

Enrollment in the DPO Plan requires you to pay a monthly premium co-payment only if you enroll yourself **and** one or more dependents. This premium co-payment is deducted each month from your paycheck or CalPERS retirement check. The current co-payments for the DPO plan are listed below.

- | | |
|--|----------------|
| • Party Code 1 (Self only) | \$ 3.63 |
| • Party Code 2 (Self plus one dependent) | \$11.31 |
| • Party Code 3 (Self plus two or more dependents) | \$19.39 |

NOTE: For active State employees enrolled in the Consolidated Benefits program (CoBen), the monthly premium co-payment may vary depending on the employee's other CoBen benefit choices.

6. What is the level of benefits under the DPO Plan?

The DPO Plan provides an annual maximum benefit of \$2,000 for all enrollees who use a participating DPO dentist. There also is a \$25 annual deductible for each enrollee (maximum of \$100 per family) using a participating DPO dentist. Enrollees who receive services from non-DPO dentists must pay a \$75 annual deductible (maximum of \$200 per family). These deductibles do not apply to diagnostic and preventive benefits such as x-rays, examinations, and cleanings.

The charts on pages 24 and 25 provide additional information. For a detailed explanation of the limitations and exclusions of the DeltaPreferred Option plan, consult the Evidence of Coverage Booklet, available by calling Delta at 1-800-225-3368

F. COBRA Group Continuation Coverage

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires employers to offer continuation of dental, medical, and vision benefits to covered employees, spouses, and eligible children who lose coverage due to certain “qualifying events.” Benefits may be continued for 18 or 36 months, depending on the qualifying event. The coverage period is measured from the time of the qualifying event, and applies to each qualified beneficiary, including the covered employee or retiree, spouse, and eligible children.

The chart below lists the qualifying events for continuation coverage and the time period of the extended coverage.

COBRA Qualifying Events

<u>Benefits Continued for 18 Months</u>	<u>Benefits Continued for 36 Months</u>
<ul style="list-style-type: none"> • Voluntary Termination – Covered employee voluntarily terminates or separates from employment (e.g., retires or quits), and the termination/separation will cause a loss of coverage. • Involuntary Termination – Covered employee is involuntarily terminated from employment (other than for gross misconduct), and the termination will cause a loss of coverage. If the termination is due to “gross misconduct,” the State is not obligated to offer COBRA continuation coverage. • Reduction of time base – Covered employee's work hours are reduced voluntarily or involuntarily, and the reduction of hours will cause a loss of coverage. Reduction of hours may include: <ul style="list-style-type: none"> • Full-time to part-time • Strikes • Layoffs • Leave of Absence • Military call-up 	<ul style="list-style-type: none"> • Death – Covered employee or retiree dies, and the surviving family member is not eligible for a monthly survivor allowance from CalPERS. • Medicare coverage begins – Covered employee or retiree becomes entitled to Medicare benefits • Divorce or legal separation – Covered employee or retiree is divorced or legally separated • Domestic partnership termination – Covered employee or retiree terminates a domestic partnership (registered in the State of California). • Change in dependent status – An eligible child of a covered employee or retiree marries or turns age 23.

Under COBRA, the administrator is permitted to charge a two percent administrative fee in addition to the premium. Therefore, the cost of COBRA continuation coverage to a State employee, retiree, and/or surviving beneficiary is 102 percent of the premium previously charged to the active employee or retiree.

Monthly Premium

Once enrolled, the enrollee's monthly premiums are due by the first of each following month. If COBRA coverage is cancelled due to non-payment of premiums, the enrollee will not be reinstated.

Partial Premium Payment

If the dental plan receives a partial monthly premium, the plan will notify the enrollee of the amount of the deficiency and allow 30 days for the deficiency to be paid. All claims incurred during the month when the deficiency exists will be held pending receipt of the deficient amount.

29 Month Qualifying Event (Social Security Disability)

COBRA contains a provision that provides additional protection for qualified beneficiaries who are deemed disabled according to the Social Security Administration. If a State employee who experiences one of the "18-month" qualifying events meets the Social Security definition of disability, the employee and his or her eligible beneficiaries are entitled to continuation coverage of **29 months** (from the date of the qualifying event).

Loss of COBRA Eligibility

COBRA eligibility ceases for an employee/retiree, spouse, domestic partner, or eligible child if any of the events listed below occurs prior to the expiration of the 18 or 36-month COBRA continuation period. The State does not offer any type of conversion plan after the 18 or 36-month period has expired. The enrollee should contact the dental plan directly for information about a potential individual conversion plan.

1. State employer ceases to offer dental insurance plans;
2. Covered employee/retiree fails to pay required premiums on time;
3. A covered State employee/retiree becomes covered under another employer's plan that does not contain any exclusion or limitation with respect to preexisting health conditions;

4. A determination is reached that a State employee who received extended COBRA coverage of 29 months due to a Social Security-approved disability is no longer disabled;
5. A covered State employee's/retiree's former spouse remarries or domestic partner establishes a new domestic partnership and obtains coverage under another group dental plan; or
6. A covered employee/retiree becomes entitled to Medicare benefits while enrolled in COBRA.

For more information about COBRA Group Continuation coverage, including eligibility, rates, enrollment procedures, or qualifying events that cause termination of COBRA eligibility, contact your personnel office (if you are an active employee) or CalPERS (if you are retired).

G. Directory of State-Sponsored Dental Plans

Dental Plan Administrator

**Department of Personnel Administration
Benefits Division
1515 S Street, North Bldg., Suite 400
Sacramento, CA 95814-7243
(916) 322-0300
(916) 322-3769 FAX**

Prepaid Dental Plans

Health Net Dental
P.O. Box 57074
Irvine, CA 92619-7074
1-800-926-7828

Private Medical Care Inc. (PMI)
12898 Towne Center Drive
Cerritos, CA 90703
1-800-422-4234

SafeGuard Health Plans
95 Enterprise
Aliso Viejo, CA 92656
1-800-880-1800

GE Wellness Plan Dental
30851 W. Agoura Rd., Suite 100
Agoura Hills, CA 91301-4343
1-800-333-9561

Delta Dental Plans

DeltaPremier and DeltaPreferred Option
P.O. Box 7736
San Francisco, CA 94120
1-800-225-3368
www.deltadentalca.org/state

H. Comparison Charts

I. Benefit Overview: Indemnity, DPO and Prepaid Plans

The following chart provides a general overview of the benefits available under the State-sponsored dental plans. Consult each plan's brochure and Evidence of Coverage booklet for detailed information and plan limitations.

BENEFITS	INDEMNITY	PREFERRED OPTION	PREPAID
Type of Plan	Fee-for-Service Plan, this plan provides reimbursement for services rendered	Benefits are maximized when services are received from a participating plan dentist	Plan pays enrollee's chosen dentist a monthly fixed rate to provide services as needed
Dental Providers	Any licensed dentist, with maximum benefits for using a Delta-affiliated dentist	Any licensed dentist, with maximum benefits for using a dentist within the plan's provider network	Must select a dental provider affiliated with the enrollee's prepaid plan
Orthodontic Providers	May use any orthodontist, with maximum benefits for using a Delta-affiliated dentist	To receive maximum benefit, must use orthodontist who is affiliated with the Plan	Must use orthodontist affiliated with the enrollee's prepaid plan
Changing Providers	You may change dentists at any time	You may change at any time to another dentist affiliated with the Plan	You may change to another dentist affiliated with the plan, with prior approval
Deductibles	Basic: \$50 per person, up to \$150 annual maximum per family Enhanced: \$25 per person, up to \$100 annual maximum per family	\$25 each, up to \$100 annual maximum per family, for Plan dentist; \$75 each, up to \$200 annual maximum per family, for non-Plan dentist	No deductible
Co-payments	You pay the difference between billed charges and plan payments	You pay the difference between billed charges and plan payments	Generally no charge, with minimal co-payments for certain covered procedures
Plan Payments	Delta dentist: payment based on fees filed with Delta; non-Delta dentist: payment not to exceed Delta's set fee schedule	Plan dentist: payment based on fee agreement with Delta; non-Plan dentist: payment not to exceed Delta's set fee schedule	For procedures with co-payment, may require payment at time of treatment
Maximum Benefits per Calendar Year	Basic: \$2,000 for employee/retiree, \$1,000 per dependent; Enhanced: \$2,000 for employee and each eligible dependent	\$2,000 per employee, \$2,000 per eligible dependent	No maximum
Maximum Lifetime Implant Benefit	Not a covered benefit	\$2,500 for each employee/retiree and dependent, if using a Plan provider	Not a covered benefit

II. Coverage for Certain Procedures: Indemnity and DPO Plans

The following chart compares employee/retiree costs for certain types of procedures under the **Indemnity and DPO plans**. Consult each plan's Evidence of Coverage booklet for detailed information and plan limitations.

Type of Plan	Delta Dental				
	Basic DeltaPremier		Enhanced DeltaPremier	DPO/using Plan provider	DPO/using non-Plan provider
Who is Covered?	Represented Employees & Retirees	Dependents of Represented Employees & Retirees	Excluded Employees & Dependents	All Employees, Retirees & Dependents	All Employees, Retirees & Dependents
Diagnostic and Preventive (two cleanings annually)	0*	0*	0*	0**	20%
Basic Benefits (UCR)	10%	20%	10%	10%	20%
Crowns	20%	50%	20%	20%	50%
Bridges, Partials & Dentures	50%	50%	50%	40%	50%
Annual Deductibles	\$50*	\$50*	\$25*	\$25*	\$75
Maximum Deductible	\$150 per family	\$150 per family	\$100 per family	\$100 per family	\$200 per family
Annual Maximum	\$2,000	\$1,000	\$2,000	\$2,000	\$1,000

* Diagnostic and Preventive Benefits are exempt from the deductible.

The level of benefits and covered services reflected in the chart are based on services provided by a DPO Plan dentist; for services provided by a non-DPO Plan dentist, the level of benefits is lower. Additionally, the DPO includes a 3rd cleaning for **high-risk patients and a benefit for dental implants (up to \$2,500 lifetime maximum).

III. Coverage and Costs: Prepaid Plans

The following chart compares employee/retiree costs and benefits available through each **prepaid dental plan**. Consult each plan's brochure and Evidence of Coverage booklet for detailed information and plan limitations.

	Health Net Dental, PMI, SafeGuard, GE Wellness Plan Dental	Health Net Dental
Type of Plan	Standard	Enhanced
Who is Covered?	Represented Employees, Retirees & Dependents	Excluded Employees, Retirees & Dependents
Diagnostic and Preventive (two cleanings annually)	0	0*
Basic Benefits (UCR)	0	0
Crowns	\$50	0
Bridges, Partials & Dentures	\$65 and up	0
Annual Deductibles	No Deductible	No Deductible
Maximum Deductible	N/A	N/A
Annual Maximum	No Maximum	No Maximum

*Health Net Dental Enhanced plan provides the availability for a third cleaning to all enrollees.

IV. Orthodontic Benefits and Costs

The following chart compares employee/retiree costs for **orthodontic benefits** available through each dental plan. Consult each plan's brochure and Evidence of Coverage booklet for detailed information and plan limitations.

	Delta Dental	Health Net Dental PMI SafeGuard GE Wellness Plan Dental	Health Net Dental Standard & Enhanced
Orthodontia	DeltaPremier Plan will pay up to 50% of approved fee for orthodontia, with a lifetime maximum for this benefit of \$1,000 for employee and dependent. DPO Plan will pay up to 50% of the approved fee, with a lifetime maximum of \$1,000 for each eligible adult and \$1,500 for covered employee's/retiree's eligible children.	\$1,000, plus up to \$250 for start-up costs	\$1,000, plus up to \$250 for start-up costs

ATTACHMENT

Department of Personnel Administration
Benefits Division
DPA 025 (Rev. 06/01)
Page 1 of 2

**State of California
Dental Program
AFFIDAVIT OF ELIGIBILITY
(Economically Dependent Child)**

I, _____ understand that the Department of Personnel Administration (DPA) allows for the enrollment of a child (other than natural, adopted or stepchild) who is economically dependent upon me until the child marries or becomes age 23 (whichever comes first).

I further understand that the child must reside with me as a member of my household in a normal parent-child relationship, and that I have responsibility for at least 50% of the child's financial support.

I therefore swear (or affirm), under penalty of perjury, that _____ and those dependents that may be listed on page 2 of this document (if applicable), is/are my dependent(s), and they reside with me as a member(s) of my household in a normal parent-child relationship and at the same time their natural parent(s) do not reside with me, and that I am responsible for 50% or more of their financial support and maintenance and that the above-mentioned child or children is/are not now, nor ever been married; is/are not a foster child; is/are not eligible for or enrolled in dental benefit coverage from any other source.

I recognize this affidavit as a legally binding document and I accept responsibility for notifying my departmental Personnel Office/CalPERS immediately if there are any changes in the child's status as my dependent. I also agree to provide supporting documentation, such as tax, court or custody records when requested by my department, CalPERS or DPA at anytime as long as the child is enrolled on my State-sponsored dental coverage as my eligible dependent.

Employee/Retiree Signature: _____ Date Signed

Social Security Number: _____ Employing Agency:

City: _____ Daytime Phone Number: ()

FOR EMPLOYING AGENCY/CalPERS USE ONLY

Affidavit received on _____, by
(Authorized Agency Signature)

The Personnel Office/CalPERS (for retirees) should maintain this document in the employee's personnel file/retiree file, attached to the agency copy of the Dental Enrollment Authorization (STD. 692). Do not send a copy of affidavit to SCO or DPA.

**AFFIDAVIT OF ELIGIBILITY
(Economically Dependent Child)**

Additional economically dependent children being enrolled in the Dental Program in accordance with qualifications listed on the front side of this form.

1. _____
2. _____
3. _____
4. _____
5. _____